



MOOD DISORDERS ASSOCIATION OF MANITOBA INC.

PROVINCIAL OFFICE: 100-4 FORT STREET WINNIPEG MANITOBA R3C 1C4
PHONE: (204) 786-0987 TOLL FREE (OUTSIDE OF WINNIPEG) 1 (800) 263-1460 FAX: (204) 775-3497
WEB: depression.mb.ca E-MAIL: sdmdm@depression.mb.ca

Obsessive-Compulsive Personality Disorder (OCPD)

Source: Diagnostical and Statistical Manual of Mental Disorders
(DSM-IV & DSM-IV-TR)

Individuals with this Cluster C Personality Disorder sacrifice openness, spontaneity, and flexibility to pursue orderliness, control, and perfectionism.

Diagnostic criteria:

A pervasive pattern of preoccupation with orderliness, perfectionism, and interpersonal control, at the expense of flexibility, openness, and efficiency, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

- 1.) Is preoccupied with details, rules, lists, order, organization, or schedules to the extent that the major point of the activity is lost
- 2.) Shows perfectionism that interferes with task completion (e.g., is unable to complete a project because his / her own overly strict standards are not met)
- 3.) Is excessively devoted to work and productivity to the exclusion of leisure activities and friendships (not accounted for by obvious economic necessity)
- 4.) Is overconscientious, scrupulous, and inflexible about matters of morality, ethics, or values (not accounted for by cultural or religious identification)
- 5.) Is unable to discard worn-out or worthless objects even when they have no sentimental value
- 6.) Is reluctant to delegate tasks or to work with others unless they submit to exactly his or her way of doing things
- 7.) Adopts a miserly spending style toward both self and others; money is viewed as something to be hoarded for future catastrophes
- 8.) Shows rigidity and stubbornness

Medical treatment

Basic principles

When they are confronted with physical illness, individuals with compulsive personality disorder are particularly troubled by the sense of loss of control over bodily functions. There may be exaggerated worries about submitting to authority figures.

The patient will attempt to ward off these anxieties by redoubling efforts at composure and presenting a precisely detailed, orderly account of progression of symptoms in an emotionally detached manner.

A scientific approach on the part of the physician – as conveyed in thorough history taking and careful diagnostic workups – is reassuring and fosters the trust necessary for an effective therapeutic alliance. A well-articulated account of the disease process and treatment alternatives reassures the patient that someone is in control and that the doctor respects the patient's capacities to participate as an informed partner in the healing process. The reassurance provides a foundation upon which the patient can begin to reconstruct a sense of order in everyday life.

Patients with compulsive personality disorder are not reassured by vague impressionistic overviews of their prognosis. Patients feel most comfortable when the doctor provides documentary evidence in the form of specific laboratory test results, e.g., electrocardiograms or x-rays, or cites actual reports from the literature when presenting statistics about risk factors.

The healing process may be promoted by harnessing patients' innate thoroughness through encouraging intake and output and weight fluctuations and control of graduated exercise programs. When feasible, patients can take over management of more routine procedures, such as changing their surgical dressings. Meticulous adherence to treatment protocols will restore morale as patients regain a sense of mastery and dignity in taking charge of their lives. The physician must remain alert to the possibility that compulsive patients may wish to carry this self-healing process too far and cross the boundaries of their competence while stubbornly resisting the expertise offered by the health care team. The use of medications in these patients is generally not productive.

Hospitalization

Occasionally, when obsessional rituals and anxiety reach an intolerable intensity, it may be necessary to hospitalize the patient until the shelter of an institution and the removal from external environmental stresses bring about a lessening of the symptoms to a more tolerable level.

Antidepressant drugs

During the past decade, sporadic case reports have described dramatic improvement in severely disabled obsessive-compulsive patients after the administration of tricyclic antidepressant or monoamine oxidase inhibitors (MAOIs).

Psychosocial treatment

Basic principles

Patients with Compulsive Personality Disorder who seek treatment usually do so because of symptoms that reflect, or are similar to, diagnoses of Obsessive-Compulsive Disorder, Affective Disorder, or occasionally Paranoia.

Individual psychotherapy

Long-term psychotherapy is the treatment of choice. The focus must be on feelings rather than thoughts and would emphasize the clarification of the defenses of isolation of affect (intellectualized distancing from emotions) and displacement of hostility.

The treatment of the personality disorder itself should be *psychotherapeutic*, and may be intensive in nature if the patient is sufficiently motivated and tolerant. Needs to control and related fears of destructive impulses are important issues at all levels of treatment, from simple scheduling requests, to intellectualization and rationalization, to other resistances to fantasy and free association. Many of the characteristics which lead to a successful life for such a patient, and which appear to the inexperienced therapist to make for an excellent therapeutic candidate, are actually symptoms which can become serious impediments to psychotherapy.

The therapist must avoid competing with the patient and should be able to tolerate the patient's verbal attacks, retaining a therapeutic posture rather than allowing the session to deteriorate into an intellectual discussion or otherwise non-productive interchange. Those patients with Compulsive Personality Disorder who show signs of deteriorating toward severe rituals or paranoia under stress should probably not be treated so intensively.

As is always the case in choosing patients for insight psychotherapy, the criteria for selection depend primarily on factors other than symptoms:

- 1.) The prominence of situational precipitating events
- 2.) The capacity to relate to the physician
- 3.) Evidence of good relationships with others
- 4.) Stable work patterns
- 5.) The capacity to tolerate anxiety and depression
- 6.) The ability to express emotion
- 7.) Intelligence
- 8.) The ability to be introspective
- 9.) Flexibility in thinking and behaviour
- 10.) Motivation for change

Supportive psychotherapy undoubtedly has its place in the psychiatrist's armamentarium, especially for the group of obsessive-compulsive patients who, despite symptoms of varying degrees of severity, are able to work and make a social adjustment. The continuous and regular contact with an interested, sympathetic, and encouraging professional may make it possible for patients to continue to function by virtue of this help, without which they would become completely incapacitated by their symptoms.

Group and behavioural therapy occasionally offer certain advantages. In both contexts, it is easy to interrupt the patient in the midst of his maladaptive interactions or explanations. **Preventing the completion of his habitual behaviour** raises his anxiety and leaves him susceptible to new learning. The patient can also experience direct rewards for change, something less often possible in individual psychotherapies.

Desensitization techniques may be helpful to certain patients in removing or reducing the severity of symptoms. As in the phobias, a hierarchy of increasingly anxiety-provoking stimuli is constructed, and the patient is systematically exposed to these stimuli step by step, either in imagination or in vivo, in combination with a variety of measures applied to induce a countering relaxation.

In **flooding**, the patient is required to face the most anxiety-provoking stimuli and to experience the full tide of anxious affect thus aroused. Flooding is often combined with response prevention, called **apotreptic therapy** by some clinicians; the patients are not only confronted with the frightening stimulus, but are restrained from carrying out their defensive-compulsive actions. **Modeling** may be added to response prevention; that is, patients are accompanied by the therapist, who remains calm and inactive during the exposure to the arousing stimulus and who provides patients with a model after which to pattern their own behaviour.

Therapeutic techniques have also been devised to control obsessional thoughts. **Saturation** requires patients actively to concentrate on the obsessional thought without letting their minds wander. Clinical experience shows that, after 10 to 15 minutes of such concentration, the obsessional thought loses some of its attention-compelling energy, and patients are unable to keep their minds focused on it. **Thought-stopping** involves the therapist in a vigorous interaction with the patient. As the patient broods on the obsessional thought, the therapist suddenly yells "Stop!" or applies an aversive stimulus to counteract the patient's obsessional preoccupation.

Family therapy

Any psychotherapeutic endeavours must include attention to family members through the provision of emotional support, reassurance, explanation, and advice on how to manage and respond to the patient.

"The single largest barrier is ignorance."